Camper Health History

Health History Form

The information on this form is part of the applicant's acceptance process.
It is gathered to assist us in identifying appropriate care in the event of an emergency.
This side to be completed by parents/guardian of applicant

Youth INFORMATION

Last Name _____ First Name _____ MI ____ Date of Birth _____ Sex ____

Address _____ City _____ State ____ Zip Code _____ Home Phone _____

Guardian INFORMATION

Last Name _____ First Name _____ MI ____ Relationship to child _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Alternate Phone Number _____

Youth EMERGENCY INFORMATION

Last Name _____ First Name _____ MI ____ Relationship to child _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Alternate Phone Number _____

Last Name _____ First Name _____ MI ____ Relationship to child _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Alternate Phone Number _____

Insurance INFORMATION

Family Physician _____ Clinic _____ Phone Number _____

Dentist/Orthodontist _____ Clinic _____ Phone Number _____

Health/Medical Insurance Carrier _____ Policy/Group Number _____ Name of Policy Holder _____

Important---This Box Must be Completed for Attendance

This health history is correct so far as I know, and the person described has permission to engage in all prescribed Challenge activities, except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the Director to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to give permission to the physician selected by the Director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of the base area of operations.

Signature of parent or guardian_____Date_____

Is the applicant's immunizations up to date? YES NO
If no please explain_____

_____

Date of last Tetanus booster _____

Is applicant allergic to any medication? YES NO

_____ _____

_____ _____

Medication	Dosage	Times	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Health Information:_____

_____

Is the applicant currently receiving treatment? YES NO

Should treatment continue while at training? YES NO

Is the applicant under the care of medical personnel for any conditions(s)? YES NO

_____
Please explain

Health History	Yes	No
Frequent Ear Infections	[ ]	[ ]
Heart Defect	[ ]	[ ]
Convulsions	[ ]	[ ]
Diabetes	[ ]	[ ]
Epilepsy	[ ]	[ ]
Bleeding Disorder	[ ]	[ ]
Hypertension	[ ]	[ ]
ADHD	[ ]	[ ]
Other	[ ]	[ ]

Allergies	Yes	No
Hay Fever	[ ]	[ ]
Poison Ivy, etc	[ ]	[ ]
Insect Stings	[ ]	[ ]
Asthma	[ ]	[ ]
Medications(list at left)	[ ]	[ ]
Peanut	[ ]	[ ]
Latex	[ ]	[ ]
Other (specify)	[ ]	[ ]

Miscellaneous	Yes	No
Is the child a bed wetter?	[ ]	[ ]
Does the child sleep walk?	[ ]	[ ]
Is this the child's first camp?	[ ]	[ ]

For Girls

Has this child menstruated?	[ ]	[ ]
If no has she been told about menstruation?	[ ]	[ ]
Is her menstrual history normal?	[ ]	[ ]

Special instructions?

_____

_____

	YES	NO
Has applicant had any reported loss of consciousness, convulsions, or concussion?	[ ]	[ ]

_____
Please explain

Does the applicant require any dietary restrictions?_____	[ ]	[ ]
Should any activities be encouraged or limited?_____	[ ]	[ ]
Should the applicant's condition preclude his/her participation in an active program?	[ ]	[ ]

Any other concerns that the staff should be aware of? _____

_____

_____

Parent / Guardian Signature_____ Date_____